

of those who need mental health treatment in this country do not receive it.

The treatment of mental illness works. Unfortunately, only those who are able to access care can benefit from it. Most mental disorders are chronic, ongoing illnesses that require consistent and persistent treatment in order to achieve remission. It would seem unconscionable to limit the number of times a cancer patient sees their oncologist for treatment; those suffering from severe psychiatric illness should not be held to a lesser standard of care.

Despite disinformation put forth by some of my colleagues today, the concept of mental health insurance parity is not a new one. In fact, as members of Congress, we all enjoy the benefits of mental health parity that our constituents are deprived of. The Federal Employees Health Benefits (FEHB) Program has offered mental health and substance-abuse benefits on a par with general medical benefits since 2001. A convincing study of the FEHB program published by the New England Journal of Medicine in 2006 proves that the implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

Mr. Speaker, the inequity of coverage with regard to mental health and substance abuse treatment benefits is tantamount to discrimination against the mentally ill, and it reinforces the strategy of insurance companies to deny care rather than provide care. It is our duty to end this intolerable discrimination against the mentally ill, and pass H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Mr. HOLT. Mr. Speaker, it will be a landmark day when we realize that health is not just about fixing broken bones. It's about having a healthy, complete individual from head to toe. Millions of Americans suffer from mental illness of some form, conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Mental illnesses strain families and can contribute to lost productivity, unemployment, substance abuse, homelessness, or suicide. Few Americans are untouched by it. No one is immune.

Prompt and comprehensive treatment can reduce enormously these effects, but insurance companies—including government plans like Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)—frequently impose limits on coverage for mental health that are not imposed on traditional medical and surgical care. Already this year, Congress has worked to address these inequalities in the federal health programs.

Today, the House of Representatives is taking a significant step toward finally ending the insurance discrimination that has existed for decades against people with mental illness.

Representative PATRICK KENNEDY and Representative JIM RAMSTAD deserve credit for their strong leadership on the Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, which I am proud to cosponsor along with more than 270 of my colleagues. This much needed legislation would require insurance companies to provide benefits for mental health and substance abuse treatment equal to those provided for physical medical treatment.

The Paul Wellstone Mental Health and Addiction Equity Act would require that all Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, illnesses be covered, rather

than letting insurance companies determine their own scope of coverage. This is the same coverage requirements that we as Members of Congress receive under our federal employee health plan, and our constituents deserve no less coverage.

The American Psychological Association, which publishes DSM-IV, reports that lack of insurance coverage (87 percent) and cost (81 percent) are the leading factors for individuals not seeking mental health services. The Paul Wellstone Mental Health and Addiction Equity Act would solve both of these problems.

Additionally, unlike the bill working through the Senate, H.R. 1424 would not preempt state law. This is very important for the residents of my home state of New Jersey and others who already have mental health parity laws on the books. For good reason these states worry that they might be forced to reduce their coverage requirements.

We know that mental illness is treatable, yet because one third of the people affected do not receive needed treatments, mental illness remains a leading cause of disability and premature death. According to the World Health Organization, the costs related to untreated mental illness are \$147 billion each year in the United States. Those who oppose the legislation thinking it is too expensive should note this cost.

Yet, an analysis of the Paul Wellstone Mental Health and Addiction Equity Act indicates it would result in an increase of less than one percent premiums and would reduce out-of-pocket costs by 18 percent. Further, a recent article in the Journal of American Medical Association, JAMA, indicates that employers who actively encourage their employees to use mental health services actually experienced an increase in hours worked and productivity gains.

Ultimately, despite the economic arguments in favor of parity, it is not a debate about dollars and cents, but about lives saved and people restored. I recently received a letter from a constituent who is a corporate human resource director. She did not write me in that capacity, however. Instead, she wrote me "as the sister of a beloved brother who committed suicide one day after his in-patient mental health care benefit 'ran-out'." She understood and related to me not only the human resources concerns, but also and especially, the true cost of mental health and the failure to enact mental health parity. Let's work to ensure that those who need access to mental health care, get it.

Mr. TERRY. Mr. Speaker, today the House is considering H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. I strongly support the mental health community and believe that millions of Americans living with mental health illness and addiction need access to treatment. Screening and early treatment remains an important and cost-effective way of combating mental health illness and addiction.

Unfortunately, the bill before us today seeks to extend mental health treatment by stifling innovation, increasing health insurance cost to employers and employees and mandates that ALL diagnoses, such as 'jet lag' and 'caffeine intoxication' listed in the DSM-IV be covered.

A provision in H.R. 1424 also seeks to limit physician ownership in hospitals, regardless of whether those hospitals are in rural or small communities. Physician owned hospitals strive

to eliminate preventable complications and errors in order to improve patient care. Specialty care hospitals are an integral part of our community in Nebraska. They provide quality care and help keep costs down. A February article in *Forbes* highlighted a University of Iowa study which found that tens of thousands of Medicare patients' complication rates for hip and knee surgeries were 40 percent lower at specialty hospitals than at other hospitals.

Mr. Speaker, unlike the Senate bill which requires that insurance companies consider all mental ailments listed in the Diagnostic and Statistical Manual of Mental Disorders, the legislation before us goes one step further by requiring groups which offer mental health benefits to cover all diagnoses under the DSM-IV, this includes disorders such as 'jet lag' and 'caffeine intoxication.' Furthermore, groups would be required to extend current mental health benefits regardless of religious or moral objections they may have to paying for the treatment of psycho-sexual disorders or dubious complaints of less serious problems.

Finally, the bill would increase health insurance costs. The CBO estimates that by 2012, H.R. 1424 would cost \$3 billion annually, a cost which would be passed on to employers and employees.

I am concerned that the government mandate currently proposed by H.R. 1424, though well-intentioned, could actually reduce access to mental health care. Many health plans are already responding to customer demand by gradually implementing greater coverage of mental health treatments. Mandating that such coverage would be immediately equal with medical and surgical benefits could force some plans to drop mental health benefits altogether leaving Americans in need of coverage with none at all.

Mr. Speaker, I wanted to come to this floor and vote for a Mental Health Parity bill like the one I supported in the Energy and Commerce Committee last fall. Unfortunately, this is not the same legislation, and therefore I must reluctantly oppose it.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act, introduced by my distinguished colleague from Rhode Island, Representative PATRICK J. KENNEDY, but ask for a closer at Section 6, and its effect on physician-owned general hospitals.

I have opposed H. Res. 1014, the rule which provided for consideration of H.R. 1424; however, I am in support of the bill itself.

This bill permanently reauthorizes and expands the Mental Health Parity Act of 1996 to provide for equity in the coverage of mental health and substance disorders as compared to medical and surgical disorders. This legislation ensures that group health plans do not charge higher co-payments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits on mental health and addiction care than for medical and surgical benefits.

Although this legislation does not mandate group health plans, if a plan does offer mental health coverage, then this legislation would require it to offer equity in its: (1) financial requirements applied to mental health and substance-related disorders, (2) equity in treatment limitations, (3) prohibit discrimination by diagnosis, and (4) equality in out-of-network coverage.